STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	005051	A. BUILDING: _____ B. WING _____	10/23/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
INDIANA UNIVERSITY HEALTH	1701 N SENATE BLVD INDIANAPOLIS, IN 46202

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
S 000	INITIAL COMMENTS This visit was for investigation of two State hospital complaints. Complaint Number: IN00130881: Substantiated: No deficiency cited related to the allegations IN00135539: Substantiated: No deficiency cited related to the allegations Facility Number: 005051 Date: 10/22/13 and 10/23/13 Surveyor: Linda Plummer, R.N., Public Health Nurse Surveyor Indiana University Health is in compliance with 410 IAC 15-1.5-5, Medical Staff/Physician Services; 410 IAC 15-1.6.4, Out Patient Services; and 410 IAC 15-1.6.9, Other Services (Discharge Planning), Hospital Licensure Rules. QA: claughlin 11/01/13	S 000		